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ABSTRACT

This paper is addressed to pscyhology graduate students who are considering a practicum experience in a community-oriented agency or institution. It contains several broad generalizations, all of which have notable exceptions. Some of these generalizations are: (1) the medical model still reigns supreme, with people in control of community mental health centers interested in little more than treating people in the community--this service means outpatient psychotherapy and inpatient ward management; (2) the caretaker and the advocate differ in how they resolve one of the basic problems of community intervention, setting limits of responsibility; (3) the advocate tends to engage in social action that is potentially disruptive to the social system, while the caretaker usually designs programs that are therapeutic for society as a whole; and (4) caretakers are often problem-oriented while advocates are people-oriented. Although the impression is given that community workers are divided into two camps--caretakers and advocates--in reality people are inconsistent and situational factors will often determine what stance a worker assumes. Students need to make a choice between the two camps to prevent compromising both positions and ending up working only for their own interests. (Author/PC)

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Training Community Psychologists in the Reality of Community Mental Health

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This paper is addressed to psychology graduate students who are considering a practicum experience in a community-oriented agency or institution. It contains a number of very broad generalizations, all of which have notable exceptions. Nevertheless, the generalizations are worthy of consideration.

Medical Model still reigns supreme. In spite of all the talk to the contrary, you can expect the conventional disease/treatment model to guide program planning. You will find that the bulk of staff time is devoted to the traditional forms of direct service. In the outpatient department it will be some form of psychotherapy, while on the inpatient units it will be some variant of ward management. Indirect services, consultation, education, and community organization exist as afterthoughts, added on to justify the federal and state funds earmarked for community based programs. You will notice that most of the indirect services will be staffed by a few more liberal-minded workers. And usually they, and the clinicians providing direct service, will tend to mutually reject one another. Consequently, the indirect services will not be linked, practically or conceptually with direct programming. You will have to divide your time between parallel programs. Eventually you will recognize that the mental health establishment, those people in control of community mental health centers, are interested in little more than treating people in the community. At the very best they are committed to providing service where none existed before. But again service means outpatient psychotherapy, and inpatient ward management. The medical model reigns supreme. What falls outside this model

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is wrapped in ambiguity and uncertainty. Because of this, you must be prepared to make decisions about what forms of intervention are legitimate. What are you willing to participate in?

Some psychologists attempt to avoid this ethical issue by considering themselves technicians who possess value-free skills, a posture consistent with physicians' views of psychologists as ancillary technicians requiring medical supervision. This orientation is suited to total institutions with rigid hierarchies. However, in community work the psychologist is relatively free to define his role. In doing so, he tends to gravitate in one of two directions, namely, toward being a "caretaker" for social institutions or an advocate for special interest groups in conflict with social institutions.

Setting Limits of Responsibility. The caretaker and the advocate differ in how they resolve one of the basic problems of community intervention, namely, setting limits of responsibility. You will come to see that some psychologists, caretakers, embrace a theoretical position that combines elements of ecology (Kelly, 1969), general systems (Rhodes, et. al., 1968; Kalis, 1970) and human service theories (Agranoff and Fisher, 1973), an approach that encourages him to take the position of a neutral outsider whose commitment is to society as a whole. From this point of view, pathology is taken as a sign of adaptive failure (Phillips, 1968), psychotic, depressed, and delinquent behaviors are considered to be breakdowns in the personal machinery of those who cannot cope with stress or those who are ill fitted to their environment. The caretaker typically assumes responsibility both for rehabilitating these "broken" people and for modifying the social system so that poor adapters can fit in. The caretaker's dream is to change man and institution to bring about social harmony. In contrast, the advocate is inclined to limit his responsibility to a specific group or warring faction (Chatterje and Kleski, 1970; Graziano, 1968). For him the mentally ill are not necessarily failing to adapt but

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rather are adapting in an unique manner (Braginsky, et. al., 1969). Those called sick are seen as victims of a social labelling process. Since the advocate views the deviant in conflict with society, he feels compelled to join one side and forsake the other. Most often he alligns himself with the weaker faction and fights against established institutions (Reiff, 1973). Clearly, these are two quite distinct models for community intervention. Once you side with one faction it is very difficult to convince your opponent that you really have everyone's interest at heart. By the same token, once make it known that you are on no ones side, no one faction will take you entirely into their confidence.

Modes of Intervention. These two professional models are associated with quite different modes of intervention. The advocate tends to engage in social action that is potentially disruptive to the social system, while the caretaker usually designs programs that are therapeutic for society as a whole. You should recognize that caretakers view mental illness as a public health issue and, since they consider social institutions to be the breeding grounds for pathology, often devise programs for the family, school, and rehabilitative institutions. In doing so they try not to take sides in any conflict between administrators, staff, and inmates or clients. They much prefer to create an atmosphere where everyone can win. They try to adjust people to one another, and to the institution, while simultaneously encouraging institutional reform.

For example, some professionals with a caretaker orientation to school problems tried to offset the inordinately high drop-out rate in an inner-city school by placing all incoming freshman in small groups. The strategy called for forming cohesive group structures that would make the student feel more accepted by the institution. A reasonable companion plan, which was not enacted, would call for assembling the teachers in small groups where they could vent and share their frustration with these difficult students (Hassol,

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1970). Obviously, these caretakers hoped that by creating a healthy atmosphere, students and teachers would come closer together and eventually work out the problems that divided them.

The advocate, however, would not be comfortable with such a program. To begin with, he would not apply the label "drop-out" to all students. He would recognize that at least some students were victims of a "push-out." Thus, he would not consider all teachers hopelessly frustrated. He would consider the possibility that substantial numbers of teachers are quite content to see the recalcitrant students leave. Since he would assume that teachers and students are in real conflict, he could work for either side but not with both. For example, the advocate might help the students press for curricular reform or develop a procedure where dropping-out is institutionally sanctioned. Whereas in the teacher's behalf he could develop a means for eliciting the aid of volunteers to work with these troublesome students and hence take the pressure off the school. While the advocate recognizes that a project designed for one interest group may benefit the other, he chooses or rejects a strategy because it maximizes the gains of his side.

Working on Problems versus Working for People. As you might expect caretakers see advocates as troublemakers. Whereas professionals with a caretaker orientation try to reduce conflict, workers with a bias toward advocacy tend to increase conflict. This difference derives, at least in part, from the fact that caretakers are often problem-oriented while advocates are people oriented. While one strives to resolve problems that confront society, the other helps his people confront other groups. Consider the following example. One of the perennial problems facing a community mental health center is the return rate of the chronic mental patient. Community centers are easily embarrassed by high return rates, because most centers came into existence in the wave of a movement to shut down large state hospitals. This has not occurred

(Lamb, 1967). Part of problem is that the agencies and institutions that participate in a comprehensive center have different agendas. Hospitals attempt to keep inpatient stay at a respectable minimum. Short stays are good for their image. But it is difficult to defend a short stay on clinical grounds, so hospital administrators arbitrarily choose an upper limit. In the case in point, it is three weeks. After that period there is increasing effort on the part of inpatient staff to release the patient to the care of the outpatient clinics. In this comprehensive center, as in most, the outpatient clinics have no-decline option. That is, if the patient shows up at the clinic the staff must provide some treatment. Unfortunately, outpatient staff tend to find doing therapy with chronic patients unrewarding, since clients, staff contend, just want to pick up their medication. Such limited involvement with the patients results very frequently in deterioration and their return to the hospital. When this occurs the in-patient staff blame the outpatient staff for not preventing deterioration, and the outpatient workers argue back that the hospital released the patient too soon. It was in such a context that a group therapist began a program for preventing or at least delaying rehospitalization. Her approach was consistent with the research that has demonstrated that former mental patients tend to return to the hospital because they behave in a bizarre fashion in front of their family (Freemon and Simmons, 1963). She was convinced that patients would remain in the community for longer periods if family members became more tolerant of small psychotic breaks. Her plan involved bringing together family members of hospitalized psychotic patients in small groups where people could support each other in the difficult task of living with a psychotic person. The group leader hoped to create a healthy, accepting atmosphere in the home so as to reduce family conflict. At the same time, the leader hoped, that as the former patients stayed home for longer and longer periods, the conflict between the outpatient and inpatient staffs would wither away.

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An advocate would be pessimistic about the possibility of resolving all the conflicts of interest inherent in this situation. He would recognize the legitimacy of the various points of view, namely, the family of the chronic patient who feels that the home is most peaceful when the patient is away and the inpatient staff who is concerned that outpatient workers are meddling in hospital affairs, and would not dream of reconciling them.

The caretaker, in this instance, recognized the potential conflicts of interest. Still she was committed to solving the problem in such a way that all parties benefited. The group leader explained the purpose of the family-of-chronic-patients group to all concerned and asked for them not to expect immediate results. She tried to buy time, while communication between the group leader and the regular therapy staff was kept at a minimum. She hoped that the group would be accepted because it worked, because it kept chronic patients at home and out of the hospital.

The advocate could not share this hope because he doesn't believe in working for abstract goals like prevention of hospitalization. He could see how some professionals and patients might favor frequent and lengthy hospitalizations. First, he would allign himself with a specific interest group and then work with them to define the goals. Whereas the caretaker attempts to solve problems by providing something for everyone, the advocate works for people even if his efforts result in worsening the problem.

Working with people requires a different style from working on problems. To work on a problem one needs technical know-how. And to the extent that the problem or its solution involve people, they may be treated like things to be influenced and managed. The caretaker, working on systems, does not need to form personal relationships with the people of the system. In fact, he may be concerned that close relationships would corrupt his objectivity. All the caretaker need concern himself with are staffing patterns, roles, and standard

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operating procedures. If necessary, he will take into account personality quirks and eccentricities of those who irrationally block his logical problem solving. Contrastingly, the advocate feels compelled to go beyond superficial relationships. His intention to join the people, to have a sense of common purpose, calls for greater responsiveness to one another. An advocate who stands apart engenders mistrust and risks rejection.

Tentative Conclusions. You may have the impression at this point that the army of community workers are divided into two camps, namely, caretakers and advocates. In reality people are inconsistent. You will find that workers often start a project with caretaking sentiments, become intensely involved with a specific interest group, become their advocate, lose interest in that group, and return to the caretaker role by working for all. Also, you will find that situational factors determine what course a worker takes. I have observed community workers cooperating with the police in the case of teenagers caught sniffing glue, all the while feeling that they were on the youth's side. In this sort of situation they did not perceive any conflict of interest in openly telling law enforcement agents what they'd learn from the teenagers. Yet it was clear that these same workers in an institution where glue-sniffers were jailed for that crime would be reluctant to share client feedback with prison officials. In the context of total institutions most professionals identify with the powerless, the inmates. But in the context of seemingly benign institutions, the family and the schools, professionals are more apt to take on the caretaker role and keep their distance.

Perhaps, you will feel comfortable this state of affairs. It is reminiscent of much of psychology. From this point of view, caretaking and advocacy are alternative approaches to community intervention something like the difference between behavior modification and verbal psychotherapy. While one tack may be more appropriate in one setting, the other is more productive for

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another situation. Also, you can believe that eventually evaluation research will determine the situations more susceptible to change by one method rather than the other. In the mean time, though, you will have to choose between advocacy and caretaking on faith alone. In any event, make a choice. Otherwise you will continually vacillate between the two, compromising both positions and end up working only for yourself. Witness what happened to the two programs described earlier, one which was designed to prevent dropping out of highschool and the other which was developed to prevent dropping into psychiatric hospitals.

In the first few weeks of classes most students dropped out of the groups just as they dropped out of the school. Yet the group leaders and their supervisors continued to meet throughout the year. Although the program was clearly not working to prevent dropping out, it was providing the group leaders with valuable training experiences. From the point of view of the professionals interested in doing training, the program had served its purpose. In the end, the community workers were working for themselves. An incident that occurred in the group of family members of hospitalized patients points out the same principle. A serious conflict developed between an outpatient worker who was trying to keep her client out of the hospital and a member of the group who wanted to put his daughter into the hospital. The group leader was caught in the middle. She tried to avoid taking sides and under this pressure became preoccupied exclusively with the survival of her program. A short time after, the group disbanded because its leader left for another job. When community workers are not clear about their commitment to the system as a whole or to a particular interest group, they often wind up committed only to their own survival.

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